Care Management in the Digital Age:

Integrated Human Service Solutions for Real-Time Monitoring, Alerting, and Reporting

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DDNA
Developmental Disabilities Nurses Association

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Disclaimers

The opinions expressed in this presentation are those of the speaker and not necessarily those of DDNA.

The opinions expressed in this presentation should not be construed as advice to care for specific individuals

Conflicts of Interest

- Douglas Golub is Co-founder and President of MediSked, LLC

Doug Golub
President

Course Objectives

Upon completion of this presentation, you will be able to:

- Understand the current shifts in human service delivery models across the country
- Understand how technology will be used to support the goals of lowering costs and improving outcomes
- Understand best practices when adopting new initiatives

INDUSTRY OVERVIEW

Overview

The human services field has been advocating a shift to new service delivery models that focus on the integration of physical, behavioral, and long-term services and supports (LTSS), including the development and expansion of home and community-based service (HCBS) alternatives to institutional care.

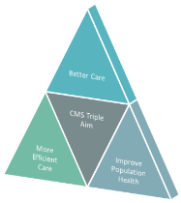
This shift, coupled with a focus on further integration into the community, promises to increase the number of providers working with each individual and expand the settings of care or support.

Source: Medicaid LTSS: Moving Forward, 2016 HCBS Conference

CMS Triple Aim Goals

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

- Better Care
  - Individual Safety, Quality, Experience
- More Efficient Care / Costs
  - Reduce unnecessary or unjustified costs
  - Reduce administrative costs through simplification
- Improve Population Health and Outcomes
  - Decrease disparities
  - Improve care management and outcomes
  - Improve community health



HCBS Settings Final Rule

Provide full access to the benefits of living in the community and the opportunity to receive services in integrated setting for individuals receiving long-term services and supports in HCBS programs under the 1915(c), 1915(i), and 1915(k) Medicaid authorities.

- Defines, describes, and aligns HCBS setting requirements across three Medicaid authorities
- Defines person-centered planning requirements under 1915(c) and 1915(i)
- Provides ability to combine multiple target populations under on 1915(c) waiver
- Establishes five-year renewal cycle to align concurrent authorities for certain demonstration projects or waivers for individuals who are dual eligible
- Includes provider payment reassignment provision to facilitate certain state initiatives

Citation: Disabled and Elderly Health Programs Group, Centers for Medicaid and CHIP Services, Final Rule Medicaid HCBS, Jan. 9, 2014.

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HCBS Settings Final Rule Extension

- CMS extended the transition period in May of 2017 to comply with HCBS setting criteria.
- Originally set to take effect in 2019, the extension provides an extra three years for states until March 2022
- States are still required to meet the 2019 deadline to obtain approval for their plans for implementation
- CMS received guidance from various stakeholders requesting extension.

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Conflict Free Case Management

- Federal regulatory requirements of conflict free case management (CFCM) under the Balancing Incentive Program (BIP) created by the ACA, the HCBS Settings Rule and the Older Americans Act
- Intended to protect the individual to ensure the process is person-centered and they are in the best position to make decisions about their care without influence
- Under BIP: The entity determining eligibility and developing the plan of care must be separate from the entity providing direct care
- Under HCBS Rule: Providers are restricted from performing case management or planning for the individual. However, if the provider is the only entity "willing and qualified," states are required in Section 1915(i) and 1915(k) to form conflict of interest standards

Citation: Foy Gordon, Justice in Aging, Conflict Free Case Management: Themes in States Working to Implement New Systems, Oct. 2014

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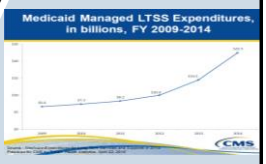
Move to Managed Care

- Many states are moving to managed care to deliver services through enrollment into an Managed Care Organization (MCO) or Accountable Care Organization (ACO) to reduce costs and increase quality of care
- States can implement managed care using three types of federal authorities:
  - State plan authority 1932(a)
  - Waiver authority 1915(a) and 1915(b)
  - Waiver authority 1115
- Over 55 million people receive benefits through some form of managed care, either on a voluntary or mandatory basis



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Unique Challenges for ID/DD Managed Care Electronic Records

Most Electronic Records for managed care companies have been developed for MLTC or Health Care for the elderly and physically disabled, so they:

1. Are problem based
2. Address end of life issues
3. Result in directions to the care manager, not to the various providers of service
4. Do not integrate data from disparate systems
5. Are not person centered

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EHRs & INTEROPERABILITY

"By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care."

President George W. Bush, State of the Union Address, January 20, 2004

Health Information Technology

For over three decades, both the public and private sector have encouraged the development of interoperable health information technology (HIT) to improve clinical and population health outcomes, increase transparency and efficiency, empower individuals, allow for more robust research data.

With respect to more traditional healthcare, goals of recent federally funded programs have focused on:

- Improving quality, safety, efficiency, and reduce health disparities
- Engaging patients and family
- Improving care coordination, and population and public health
- Maintaining privacy and security of patient health information

Health information technology has taken many forms to meet these objectives, including electronic health record (EHR) systems, health information exchanges (HIEs), web and mobile offerings, telehealth and remote patient monitoring solutions, etc.

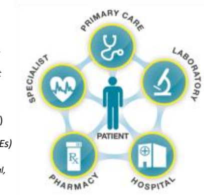
What is a Health Information Exchange?

According to The Office of the National Coordinator for Health Information Technology (ONC):

> *"Electronic health information exchange (HIE) allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety and cost of patient care."*

As of 2014, the Agency for Healthcare Research and Quality (AHRQ) identified that *"although estimates vary depending on the data source, there are as many as 280 health information exchanges (HIEs) in the United States…*

- *One-half of the nation's hospitals are now participating in a regional, state, or private HIE;*
- *71% plan to buy new HIE technology in the next two years; and*
- *Nearly one-half of the nation's physicians plan to join an HIE"*



HIEs: A Chronological Overview

1985 — **Community Health Information Networks (CHINs):** 1985-Present
"A community health information network is an organizational and technical entity designed and operated to facilitate the electronic data interchange and integration of various types of health care information for the benefit of those organizations and health care professionals that participate in the network."

While nearly all CHINs disappeared over time, two evolved and are still present today:

- Wisconsin Health Information Network (founded 1993)
- Utah Health Information Network(founded 1993)

1991 — **Community Health Management Information System (CHMIS):** 1991-1996
Create both a data network and a data repository to measure cost and quality from competing providers in a given community.

Financed grants created resulted CHMIS implementations in seven states: MN, IA, VT, WA, NY, and TN

1996 — **Electronic Data Interchange (EDI):** 1996 (defined) - Present
Why talk about Electronic Data Interchange (EDI)?

Without a **standards-based approach to data sharing** between organizations, the on-going evolution of exchanging data might have remained a difficult obstacle for the entire healthcare industry.

Originating out of proprietary standards implemented in the mid-1970s, today's EDI standards were defined in 1996 by the National Institute of Standards and Technology (NIST). Since then, a number of bodies have continued to work on EDI for all types of healthcare data.

2004 — **Office of the National Coordinator for Health Information Technology (ONC):** 2004 - Present
A principal federal entity with the Department of Health & Human Services; charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information.

2004 — **National eHealth Collaborative (NeHC):** 2004-2012
National eHealth Exchange: 2012 - Present
A program founded under ONC, NeHC was a public-private partnership that enabled secure and interoperable nationwide health information exchange to advance health and improve healthcare.

In 2012, the eHealth Exchange transitioned to operate as a public-private partnership under Healtheway (now the Sequoia Project), where it continues to operate today.

2004 — **Nationwide Health Information Network (NHIN):**
Health Information Network Exchange:

2005 — **American Health Information Community (AHIC):** 2005-2008
ONC's initial engagement model, AHIC was a federal advisory body to make recommendations to the Secretary of the U.S. Department of Health and Human Services on how to accelerate the development and adoption of health information technology.

2005 — **Health Information Technology Standards Panel (HITSP):** 2005-2010
Founded to define healthcare information standards, HITSP is a strategic partnership established through a contract with the U.S. Department of Health and Human Services.

2011 — **Standards & Interoperability Framework (S&I):** 2011 - Present
Launched in 2011 by ONC and managed by ONC's Office of Interoperability and Standards, the S&I Framework is the next generation of HITSP.

The S&I Framework is a set of integrated functions, processes, and tools being guided by the healthcare and technology industry to achieve harmonized interoperability for healthcare information exchange.

Integration enables the two-way transfer of human services data

Providers and the individual benefit from the ability to access social and human services data for an individual. The breadth of data can vary based on the specific systems, including the following:

- Summary Notes
- Person Centered Assessment
- Integrated CQL Personal Outcome Measures (POM), CARF Measures
- Integrated Health and Safety Supports, Individual Protective Oversight Plans
- Individualized Service Plans
- Claims data
- Electronic care coordination systems with communications among teams, including circle of supports, Medical, Long Term Care, DD, and DME providers

Types of Data Shared

- Person Information
- Information Source
- Hospital Admissions and Discharges
- Diagnoses
- ER Results
- Encounters
- Lab and Radiology Results
- Allergies
- Prescriptions
- Problems
- Procedures
- Vital Signs
- Immunizations

Look for a Standards Leader

Look for a vendor who is a member of the Object Management Group (OMG), and has led the efforts to define care coordination service standards for the long term services and supports industry.

CLINICAL SCENARIO

Meet Karen

I have difficulty communicating, however, people who know me can understand me well. They can tell what I like and dislike. I can gesture to communicate what I want and I am capable of speaking simple phrases. I am wheelchair bound and require full assistance from staff with my ADL skills. I enjoy being around my housemates and staff. I enjoy watching TV in the living room. I sometimes participate in seated exercises. One of my favorite activities is art therapy where I create water color paintings. My hobby is to collect hair scrunchies and wear them on my wrist. I like the feel of stuffed animals and hold them close to me.

Karen lives in a supervised residence with 3 other women.
In December 2016, she went to the ED on two separate occasions

- Ankle fracture
- Leg abscess

While Karen recovered, her team wanted to address what could be done to reduce situations like these in the future

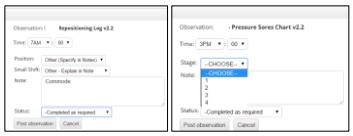
What Happened Next?

After reviewing the recent hospitalizations, Karen's charting requirements were modified to include the Repositioning Log every 1-2 hours, and a new chart for Pressure Sores

Charts were now completed within the agency's EHR platform

Karen's Charts

- Pressure Sore Chart
- Repositioning Log
- Fluid Intake
- Sleep Log
- Finger Stick Monitor
- Seizure Record
- BM Chart



What Happened Next?

The result?

- Karen had multiple staff members that she worked with and everyone needed to be on the same page
- Staff were prompted to chart during their shift by a pop-up alert
- Staff could see what was logged earlier in the day
- Thresholds were put in place so that if certain readings were reported, staff would issue an immediate alert
- The nursing team could run a real-time report to determine if there were any items that required further monitoring or interventions
- The team could review and confirm that these issues did not reoccur for Karen
- Supervisors could identify if staff required additional training in relation to working with Karen

What Happened Next?

Karen also needed a new wheelchair, which required conversations with multiple providers and vendors Within the EHR, the agency was able to:

- Track when contact was made, and with whom
- Attach all documents in relation to the process in one place
- Keep on top of scheduled adjustments and Karen's feedback on how the process was going

Contacts were also set up to receive alerts if Karen were to return to the hospital, through an interface provided by the HIE/HIO

The result?

- Everyone who works with Karen will now receive a notification if she does return to the hospital
- Adoption of process for a workflow when someone is discharged from the hospital
  - Intent to stay on top of any new medications/instructions as well as decrease recurrence
- Team is up to date on new wheelchair efforts, so consistent messaging is available regarding updates

BEST PRACTICES

1. Improve communication among providers, individuals, and their circles of supports to eliminate barriers, increase transparency, and empower individuals to drive their services

- Include technology in strategic plans with tactics that give true authority back to the individual in all aspects of decision making for their life
- Promote meaningful relationships and things of value to the individual
- Utilize technology that is extensible to support third-party data via interface integrations
- Allow for direct flow of information to the individual and all interdisciplinary team members based on credentials and the role they play in the person's life
- Allow individuals and their team members to send secure messages

2. Effectively engage individuals in the person-centered planning process - from assessments to individual service plans, tools and tactics to improve collaboration among individuals, providers, and circles of supports

- Use technology to promote supports centered around individualized goals and outcomes
- Unite employees providing different supports around the same person through messaging functionality
- Provide access to members of the team that do not use an EHR to view important aspects of the individual's record

3. Deliver cost-effective and time-efficient case management - exploring new, integrated delivery channels and opportunities

- Utilize opportunities that reduce duplication of efforts
- Provide at-a-glance information that supports individuals with the highest level of need first by identifying priority
- Reframe the work of assessment and plan development into a seamless process by entering assessment data directly into electronic record

4. Measure, monitor, and improve outcomes and quality in community-based settings by tracking and sharing qualitative and clinical information among team members in real-time

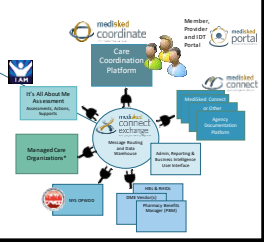
- Possess the ability to implement mobile documentation that can be transferred into usable data for outcome reports
- Allow for flexibility based on the business rules of your agency for tracking evidence-based outcomes
- Provide configurable plan templates which act as valuable tools to ensure services provided are making progress towards the individual's specifically outlined goals

5. Be an informed buyer

- Create a "wish list" for information you want access to, with a plan for what you would do with it
- Be aware of all the options so you can consider the best system for your organization
- Stay informed of what is happening in the regulatory climate to ensure the solution you choose is compliant with the regulations

CASE STUDIES

Case Study: Partners Health Plan: Data sharing across providers for Managed Care



- MediSked's electronic systems are integrated to allow for distribution and review of critical individual's data in real time.
- Connect Exchange is Platform Agnostic, meaning that any HL7-compliant EHR can adapt to participate
- This solution allows for the individual, their Inter-Disciplinary Team (IDT) and providers to log and respond to Member events as they happen.

Implementing Electronic Records Across an Agency Spanning a State

The Arc North Carolina

Dave Richard

- Former Arc of North Carolina Executive Director
- Current Deputy Secretary at the Department of Health & Human Services

We provide services across the entire state and what we do on the direct service side is very individualized supports within remote community settings – the ability to have a system that crosses the state, that we can put all of the information we need to in one place is so important. We can have a leader in Wilmington, North Carolina look at the same information in real time as somebody that's out in the mountains of western North Carolina absolutely allows us to have confidence that we have the right information, confidence that we have the compliance information, even better, the opportunity to make good decisions and to have our staff aligned in the right places.

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Case Study with ResCare

Jon Rousseau
- President and CEO of ResCare

Our partnership with MediSked sets another precedent in our industry. With the addition of an electronic health record (EHR) to our industry care management solutions that include pharmacy, behavioral health services and remote monitoring and caregiving technologies, we're establishing a Connected Home model of care across the breadth of our states and people served, today and over the coming years. Our model will lead the way for needed innovations in care solutions that push our industry forward to work smarter, improve connections across teams and homes, and improve the quality of care and safety outcomes for individuals in the communities we serve – helping them to live their best life

Executed in early 2017
Residential (ICF/Waiver) Program in Phase 1:
- 18-month roll-out to 28 states

- Collecting ADLs/IADLs
- Service Notes
- Incident Reports

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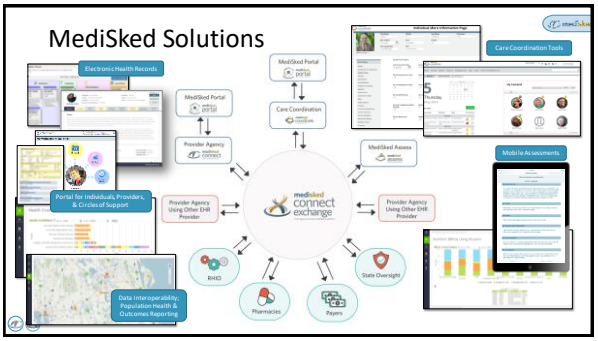
MediSked Solutions



Bringing it all together

- Shifts in human service delivery models across the country are moving towards managed care, integrated care management, and conflict-free case management
- Technology solutions are being used to support the goals of lowering costs and improving outcomes
- When adopting new initiatives, remember best practices and the needs of your organization

THANK YOU
QUESTIONS?